b. the regional committee and based on their recommendation.

E. Procedural Requirements

1. Dispatch personnel will coordinate to the extent possible trips for family members so that all recipients in a family are transported as a unit at one time to the same or close proximity providers.

2. Providers must submit a signed affidavit with claims certifying that a true and correct bill is being submitted.

3. If the provider has declined to accept a trip on a particular day the dispatch personnel will not assign additional trips to that provider for that same day.

F. Suspensions and Terminations

Providers are subject to suspension from the Nonemergency Medical Transportation Program upon agency documentation of inappropriate billing practices.

Interested persons may submit written comments to Thomas D. Collins, Office of the Secretary, Bureau of Health Services Financing, Box 91030, Baton Rouge, LA 70821-9030. He is the person responsible for responding to inquiries regarding this emergency rule and providing information regarding the public hearing. At that time all interested parties will be afforded an opportunity to submit data, views or arguments, orally or in writing at said hearing. Copies of this emergency rule and all other Medicaid rules and regulations are available at parish Medicaid offices for review by interested parties.

Rose V. Forrest
Secretary

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Standards for Payment for Hospital Specialty Units

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, has adopted the following emergency rule in the Medical Assistance Program as authorized by R.S. 46:153. and pursuant to Title XIX of the Social Security. This emergency rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B) and shall be in effect for the maximum period allowed under the Administrative Procedure Act.

Hospital reimbursement policy has permitted that services delivered in certain resource-intensive hospital units, neonatal, pediatric, burn and transplant units be "carved out" for reimbursement purposes. This procedure allowed the reimbursement of these services to be made outside the TEFRA cost per discharge limitation in order to ensure that Medicaid beneficiaries are able to obtain these services in state. The hospital prospective payment methodology rule effective July 1, 1994 continues this cost identification process through the use of a peer grouping of these units wherein the provision of appropriate facilities, equipment and personnel essential for the effective management of the patient groups involved are recognized. This rule also includes the criteria for the inclusion of such specialized units in the appropriate peer grouping. In conjunction with this rule the bureau has adopted the following rule entitled "Standards for Payment for Hospital Specialty Units" which will be utilized by the health standards sections to determine the hospital's compliance with the criteria established for these units. The fiscal impact associated with the adoption of these standards for the neonatal, pediatric, burn and transplant specialty units has already been included in the analyses completed for the adoption of the hospital prospective payment methodology rule which reflect approximately $2,184,029 of total increased expenditures for state fiscal year 1995 for these units.

Emergency Rule

Effective July 1, 1994, the Bureau of Health Services Financing has adopted criteria entitled Standards for Payment for Hospital Specialty Units which establish requirement for Medicaid reimbursement for specialized neonatal and pediatric intensive care, burn and transplant services to Medicaid recipients. These requirements are as follows.

I. Neonatal Care Units

Level I Unit

1. Unit Mission

a. To evaluate the condition of healthy neonates and provide continuing care of these neonates until their discharge in compliance with state regulations regarding eye care, hearing screening, and metabolic screening.

b. To stabilize unexpectedly small or sick neonates before transfer to a Level II, Level III, or Level III Regional NICU unit.

c. To maintain consultation and transfer agreements with Level II, Level III and Level III Regional NICU units, emphasizing maternal transport when possible.

2. Minimum Levels of Care

a. Resuscitation and stabilization of all inborn neonates.

b. Nursery defined area with limited access and security or rooming-in facilities.

c. Parent-neonate visitation/interaction must be provided.

d. Data collection and retrieval.

3. Medical Staff Neonatal

a. A Level I ~~NICU~~ unit medical director and/or department chief must be a board eligible or board certified pediatrician; or a board eligible or board certified family practitioner on staff.

4. Nursing Staff

a. A nurse manager dedicated for the neonatal care area shall be available to all units. The nurse manager shall have specific training and experience in Neonatal Intensive Care. The nurse manager shall participate in the development of written policies and procedures for the neonatal care areas, coordinate staff education and budget preparation with the medical director. The nurse manager shall name qualified substitutes to fulfill his or her duties during their absences. Nurse to patient ratios will vary with patient needs; however, the range for Level I will be 1:8.

Level II Unit

1. Unit Mission. A Level II NICU unit must be capable o

the following:

a. Must meet all requirements of all Level I NICU unit services at a superior level.

b. To provide management of small, sick neonates with a moderate degree of illness that are admitted or transferred.

2. Minimum Levels of Care

a. Performance of all Level I NICU unit services at a superior level.

b. Neonatal ventilatory support, vital signs monitoring, and fluid infusion in defined area of the nursery.

c. Neonates born in a Level II NICU unit with a birth weight of less than 1000 grams must be transferred to a Level III or Level III Regional NICU unit once they have been stabilized if they require prolonged ventilatory support or have life threatening diseases or surgical complications requiring a higher level of care.

d. Neonates with a birth weight in excess of 1000 grams who require prolonged ventilation therapy may be cared for in a Level II NICU unit, provided such unit performs a minimum of 72 days of ventilator care annually. A day of ventilator care is defined as any period of time during a 24-hour period.

e. If a Level II NICU unit performs less than 72 ventilator days per year, it must transfer any neonate requiring prolonged (greater than 24 consecutive hours) ventilator therapy to a Level III or Level III Regional NICU unit. Neonates requiring transfer to a Level III or Level III Regional NICU unit may be returned to a Level II NICU unit for convalescence.

3. Medical Staff

a. A board certified pediatrician of a Level II NICU unit with subspecialty certification in neonatal medicine must be the medical director and/or department chief.

In existing units, consideration will be given to waiving this requirement for board certified pediatricians with a minimum of five years experience in neonatal care who are currently serving as medical directors of Level II units. The request for waiver must be made in writing to the Office of the Secretary.

4. Nursing Staff

a. A nurse manager dedicated for the neonatal care area shall be available to all units. The nurse manager shall have specific training and experience in development of written policies and procedures for the neonatal care areas, coordinate staff education and budget preparation with the medical director. The nurse manager shall name qualified substitutes to fulfill his or her duties during their absences. Nurse to patient ratios will vary with patient needs; however, the range for Level II will be 1:3-4.

5. Support Personnel. The following support personnel should be available to the perinatal care service of Level II and Level III NICU units:

a. At least one full-time medical social worker who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families (additional medical social workers may be required if patient load is heavy).

b. At least one occupational or physical therapist with neonatal expertise.

c. At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates.

d. Qualified personnel for support services such as laboratory studies, radiologic studies, and ultrasound examinations (these personnel should be readily available 24-hours a day).

e. Respiratory therapists or nurses with special training who can supervise the assisted ventilation of neonates with cardiopulmonary disease (optimally, one therapist is needed for each four neonates who are receiving assisted ventilation).

Level III Unit

1. Unit Mission. A Level III NICU unit must be capable of the following:

a. must meet all requirements of all Level I and II NICU unit services at a superior level;

b. provision of comprehensive care of high-risk neonates of all categories admitted and transferred;

c. a Level III NICU unit will have a neonatal transport agreement with Level III Regional unit and will be involved in organized outreach educational programs.

2. Minimum Levels of Care

a. There must be one neonatologist for every 10 patients in intensive care (Level III NICU unit) area. If the neonatologist is not in-house, there must be one licensed physician who has successfully completed the Neonatal Resuscitation Program (NRP), or one neonatal nurse practitioner in-house for Level III NICU unit patients who require intensive care. A five year phase-in period will be allowed in order for the hospital to recruit adequate staff to meet these requirements.

b. Obstetrics and neonatal diagnostic imaging, provided by obstetricians or radiologists who have special interest and competence in maternal and neonatal disease must be available 24-hours a day.

c. A Level III NICU unit shall have a neonatologist or a licensed physician (who has successfully completed the Neonatal Resuscitation Program (NRP), or a neonatal nurse practitioner in-house at all times.

3. Medical Staff

a. The medical director and/or department chief of a Level III NICU unit must be a board-certified pediatrician with subspecialty certification in neonatal medicine. The following exceptions are recognized.

1) Board eligible neonatologists must achieve board certification within five years of completion of fellowship training.

2) In existing units, consideration will be given to waiving this requirement for neonatologists who are currently Medical Directors and/or department chiefs of Level III NICU's. The request for waiver must be made in writing to the Office of the Secretary/Bureau of Health Services Financing. This exception applies only to the individual at the hospital where the medical director and/or department chief position is held. The physician can not relocate to another hospital nor can the hospital replace the medical director and/or department chief for whom the exception was granted and retain the exception.

3) There must be one neonatologist for every 10 patients in the intensive care Level III NICU unit area. If the

neonatologist is not in-house, there must be one licensed physician (who has successfully completed the neonatal resuscitation program (NRP), or one neonatal nurse practitioner in-house for Level III NICU unit patients who require intensive care. A five year phase-in period will be allowed in order for the hospital to recruit adequate staff to meet these requirements. A Level III NICU unit shall have a neonatologist, or a licensed physician (who has successfully completed the neonatal resuscitation program (NRP), or a neonatal nurse practitioner in-house at all times.

b. Medical and surgical consultation must be readily available and pediatric subspecialists may be used in consultation with a transfer agreement with a Level III Regional NICU unit.

4. Nursing Staff

a. A nurse manager dedicated for the neonatal care area shall be available to all units. The nurse manager shall have specific training and experience in the development of written policies and procedures for the neonatal care areas, coordinate staff education and budget preparation with the medical director. The nurse manager shall name qualified substitutes to fulfill his or her duties during their absences. Nurse to patient ratios will vary with patient needs; however, the range for Level III NICU unit will be 1:2-3.

5. Support Personnel. The following support personnel shall be available to the perinatal care service of Level II and Level III, and Level III Regional NICU units.

a. At least one full-time medical social worker who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families (additional medical social workers may be required if the patient load is heavy).

b. At least one occupational or physical therapist with neonatal expertise.

c. At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates.

d. Qualified personnel for support services such as laboratory studies, radiologic studies, and ultrasound examinations (these personnel shall be readily available 24-hours a day).

e. Respiratory therapists or nurses with special training who can supervise the assisted ventilation of neonates with cardiopulmonary disease (optimally, one therapist is needed for each four neonates who are receiving assisted ventilation).

Level III Regional Unit

1. Unit Mission. A Level III Regional NICU unit must be capable of the following:

a. must meet all requirements of all Level I, II and III NICU unit services at a superior level;

b. a Level III Regional NICU unit must have a transport team and provide for and coordinate a maternal and neonatal transport with Level I, Level II, and Level III NICU's throughout the state;

c. A Level III Regional unit shall be recognized as a medical center of excellence, and a center of research, educational and consultative support to the medical community.

2. Medical Staff

a. The medical director and/or department chief must be a board certified neonatologist.

b. In addition to the medical staff requirements for a Level III NICU unit, a Level III Regional NICU unit shall have the following subspecialties on staff and clinical services available to provide consultation and care in a timely manner:

Pediatric surgery	Pediatric cardiology
Pediatric neurology	Pediatric hematology
Genetics	Pediatric nephrology
Endocrinology	Pediatric gastroenterology
Pediatric infectious disease	Pediatric pulmonary medicine
Cardiovascular surgery	Neurosurgery
Orthopedic surgery	Pediatric urologic surgery
Pediatric ophthalmology	Pediatric ENT surgery
Pediatric nutritionist	Pediatric PT/OT
Neonatal Social Services	Bioethics committee

3. Nursing Staff

a. A nurse manager dedicated for the neonatal care area shall be available to all units. The nurse manager shall have specific training and experience in neonatal intensive care. The nurse manager shall participate in the development of written policies and procedures for the neonatal care areas, coordinate staff education and budget preparation with the medical director. The nurse manager shall name qualified substitutes to fulfill his or her duties during their absences. Nurse to patient ratios will vary with patient needs; however, the range for Level III Regional unit will be 1:1-2.

4. Support Personnel. The following support personnel shall be available to the perinatal care service of Level I, II, III, and III Regional NICU units:

a. at least one full-time medical social worker who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families (additional medical social workers may be required if the patient load is heavy);

b. at least one occupational or physical therapist with neonatal expertise;

c. at least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates;

d. qualified personnel for support services such as laboratory studies, radiologic studies, and ultrasound examinations (these personnel shall be readily available 24-hours a day);

e. respiratory therapists or nurses with special training who can supervise the assisted ventilation of neonates with cardiopulmonary disease (optimally, one therapist is needed for each four neonates who are receiving assisted ventilation).

Pediatric Intensive Care Units

The new reimbursement methodology recognizes two categories of Pediatric Intensive Care Units (PICU). Although pediatric critical care is provided primarily at one level there